

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/10/2012	
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of complaint numbers IN00115335 and IN00114241.</p> <p>Complaint number IN00115335- Unsubstantiated due to lack of evidence.</p> <p>Complaint number IN00114241 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 7 and September 10, 2012</p> <p>Facility number: 011906 Provider number: 155772 AIM number: 200912380</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN Laura Brashear RN</p> <p>Census bed type: SNF 48 SNF/NF 9 Residential 32 Total 89</p> <p>Census payor type: Medicare 34 Medicaid 4 Other 51 Total 89</p> <p>Sample 17</p> <p>Cobblestone Crossing Health Campus was found to be in compliance with 42 CFR Part 483,</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Subpart B and 410 IAC 16.2 in regards to the Investigation of Complaints IN00115335 and IN00114241. Quality review completed 9/11/12 Cathy Emswiller RN			F 000			